

APPENDIX E-1

TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION FORM DPA 1443, PROVIDER INVOICE

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed character per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photo-coping a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims.

Appendix E-1a is a copy of Form DPA 1443, Provider Invoice. Instructions for completion of the Provider Invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude the Department's correction of certain billing errors.
Conditionally Required	=	Entries which are required based on entry in another field. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of audiology services.

COMPLETION STATUS

ITEM

Document Control Number - leave blank.

- | | |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 1. Provider Name - Enter the provider's name exactly as it appears on the Provider Information Sheet. |
| Required | 2. Provider Number - Enter the Provider Number exactly as it appears on the Provider Information Sheet. |
| Required | 3. Payee - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. |

If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.

- | | |
|--------------|--------------------------------|
| Not Required | 4. Group - Leave blank. |
| Not Required | 5. Role - Leave blank. |

Conditionally Required	<p>6. Acc/Inj - This is a one-digit numeric field. When applicable, enter one of the following Accident/Injury Codes to indicate the probable reason the patient sought treatment.</p> <ul style="list-style-type: none"> 1 - Employment - The patient's injury is due to work related accident or illness. 2 - Motor Vehicle - The patient's injury was received while operating a motor vehicle or as a passenger in a motor vehicle, or another type of accident involving a motor vehicle. 3 - Athletic - The patient's injury is due to participation in an organized sport or school activity. 4 - Victim - The patient's injury is due to an act of violence (non-accidental). 5 - Other - The patient's injury is the result of an unspecified accident.
Optional	<p>7. Provider Reference - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is completed, the same data will appear on Form DPA 194-M-1, Remittance Advice, returned to the provider.</p>
Optional	<p>8. Provider Street - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the Department will not attempt corrections.</p>
Conditionally Required	<p>9. Facility & City Where Service Rendered - This entry is required when Place of Service Code in any Service Section is other than A (provider's office) or K (patient's home).</p>
Not Required	<p>10. Prior Approval - Leave blank.</p>
Optional	<p>11. Provider City State Zip - Enter city, state and zip code of provider. See Item 8 above.</p>
Required	<p>12. Referring Practitioner Name - Enter the name of the otologist, otolaryngologist or primary physician who referred the patient for audiology services.</p>
Required	<p>13. Ref. Prac. No. - Enter the referring practitioner's state license number, Social Security Number or AMA number.</p>

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|-------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 14. Recipient Name - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card or KidCare Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field. |
| Required | <p>15. Recipient No. - Enter the nine-digit number assigned to the individual as copied from the MediPlan Card, Temporary MediPlan or KidCare Card. Use no punctuation or spaces. Do <i>NOT</i> use the Case Identification Number.</p> <p>If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birthdate on the Provider Invoice and attach a copy of the Temporary MediPlan Card to the Provider Invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached.</p> |
| Conditionally Required | 16. Birthdate - Enter the month, day and year of birth of the patient as shown on the MediPlan Card, Temporary MediPlan Card or KidCare Card. Use the MMDDYY format. |
| Not Required | 17. Healthy Kids - Leave blank |
| Not Required | 18. Fam Plan - Leave blank |
| Not Required | 19. Cr. Child - Leave blank |
| Not Required | 20. St/Ab - Leave blank |
| Required | 21. Billing Date - Enter the date the Provider Invoice was prepared. Use MMDDYY format. |
| Required | 22. Primary Diagnosis - Enter the primary diagnosis which describes the condition primarily responsible for the patient's treatment. (The diagnosis should be provided by the referring specialist or primary physician.) |
| Conditionally Required | 23. Prefix - When the diagnosis code in the ICD-9-CM has an alphabetic prefix of "E" or "V," enter it here. |

Required	24. Diag. Code - Enter the ICD-9-CM code for the diagnosis described in 22 above. All characters to the left of the decimal point should be entered to the left of the dividing line. All characters to the right of the decimal point should be entered to the right of the dividing line.
Not Required	25. Secondary Diagnosis - Leave blank
Not Required	26. Prefix - Leave blank
Not Required	27. Diag. Code - Leave blank
	28. Service Sections: Complete one service section for each item or service provided to the patient.
Required	Procedure Description/Drug name, Form, and Strength or Size - Enter the Description of the service provided or item dispensed.
Required	Proc. Code/Drug Item No. - Enter the appropriate five-digit CPT, HCPCS or Department-generated code for the service or item. Refer to Topic E-202 for information on obtaining a list of all covered services and items.
Conditionally Required	Delete - When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.
Required	Date of Service - Enter the date the service was provided. Use MMDDYY format.
Required	Cat. Serv. - Enter the appropriate two-digit code for the category of service provided. The applicable code is: 14 - Audiology Services
Required	Place of Serv. - Enter the one letter Place of Service Code from the following list: A Provider's Office H Long Term Care Facility I Sheltered Care Facility K Patient's Home L Other Location
Not Required	Units/Quantity - Leave blank

Not Required

Modifying Units - Leave blank

**Conditionally
Required**

TPL Code - If the patient's MediPlan or KidCare Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required except as follows:

SPENDDOWN - Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. If the patient has a Spenddown obligation, they will either be responsible for the total amount of the charge or will present the provider with a Form DPA 2432 (Split Billing Transmittal). When a Form DPA 2432 is necessary, Form DPA 1443, must be completed as follows:

- Enter 906 in the TPL CODE field.
- Enter a 01 in the TPL STATUS field if there is a patient liability or enter a 04 in the TPL STATUS field if there is no patient liability.
- From the Form DPA 2432, enter the amount from the LESS RECIPIENT LIABILITY AMOUNT field in the TPL AMOUNT field on the Form 1443. This amount may be \$0.00.
- From the Form DPA 2432, enter the DATE from the bottom of the form in the TPL DATE field of the Form DPA 1443.
- The TPL fields must be completed in each Service Section that has the same date of service as the SPLIT BILL day. The Spenddown liability is to be divided and reported in the TPL AMOUNT field of each Service Section that has the same date of service. A Form DPA 2432, Split Billing Transmittal, for the split bill date of service, indicates a Spenddown patient and code 906 is to be entered in the TPL CODE field. Other pertinent entries in such a case are included in the designations shown below. Form DPA 2432 is to be attached with Form DPA 1443, Provider Invoice.

**Conditionally
Required**

Status - If a TPL code is shown in Item I, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code = 000.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown: TPL Status Code 01 is to be entered when payment has been received from the patient's third party resource. The amount of payment received *must* be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status Code 02 is to be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered: TPL Status Code 03 is to be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met: TPL status code 04 is to be entered when the patient's Form DPA 2432, Split Billing Transmittal, shows \$0.00 liability.

05 - Patient not covered: TPL Status Code 05 is to be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered: TPL Status Code 06 is to be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

08 - Third Party Estimated Payment: TPL status code 08 is to be entered when contact has been made with the third party and payment is forthcoming, but has not yet been received. The provider is responsible for initiating an adjustment if the actual amount of TPL monies received differs from the Estimated Amount reported.

10 - Deductible not met: TPL Status Code 10 is to be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally
Required**

TPL Amount - If there is no TPL code, no entry is required. Enter the amount of payment received from the third party health resource or the patient. A dollar amount entry is required if TPL Status Code 01 or 08 was entered in the "Status" box.

**Conditionally
Required**

Adjudication Date - A TPL date is required when any status code is shown. Use the date specified below for the applicable code:

Code	Date to be entered
01	- Third Party Adjudication Date
02	- Third Party Adjudication Date
03	- Third Party Adjudication Date
04	- Date from the DPA 2432
05	- Date of Service
06	- Date of Service
07	- Date of Submittal to TPL Resource
10	- Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Optional	Repeat - In the second through seventh Service Sections, a field titled "Repeat" appears at the beginning of the Service Section. This field may be used, by entry of a capital "X" in the box, to eliminate the need to repeat any data field except the Date of Service and any TPL related fields.
Not Required	29. Optical Materials Only - Leave blank. Charges and Deductions Section -The information field in the lower right of the Provider Invoice is to be used: 1) to identify additional third party resources in instances where the patient has access to two or more resources and 2) to calculate total and net charges. If a second third party resource was identified for one or more of the services billed in Service Sections 1 through 7 of the Provider Invoice, complete the TPL fields in accordance with the following instructions: Conditionally Required Sect. # - If more than one third party made a payment for a particular service, enter the Service Section number (1 through 7) in which that service is reported. If a third party resource made a single payment for several services and did not specify the amount applicable to each, enter the number 0 (zero) in this field. When 0 is entered, the third party payment shown in section 30 will be applied to the total of all Service Sections on the Provider Invoice. Conditionally Required TPL Code - Enter the appropriate TPL code referencing the source of payment. Refer to Chapter 100, Appendix 9. If the TPL Resource Codes are not appropriate, enter 999 and enter the name of the payment source in the Uncoded TPL Name field. Conditionally Required Status - Enter the appropriate TPL Status Code. Conditionally Required TPL Amount - Enter the amount of payment received from the third party resource. Conditionally Required Adjudication Date - Enter the date the claim was adjudicated by the third party resource.

**Conditionally
Required**

Uncoded TPL Name - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

The three claim summary fields must be completed on all Provider Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are to be completed in accordance with the following instructions.

Required

Total Charge - Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 7.

Required

Total Deductions - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000).

Required

Net Charge - Enter the difference between Total Charge and Total Deductions.

Required

31. # Sects - Enter the total number of Service Sections completed correctly in the top part of the form. This entry must be at least one and no more than 7. Do not count any sections which were deleted because of errors.

Not Required

32. Original DCN - leave blank.

Not Required

33. Original Voucher Number - leave blank.

Required

Provider Certification, Signature and Date - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Billing forms received with a stamped or facsimile signature will be rejected. Unsigned Provider Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date is to be entered.

MAILING INSTRUCTIONS

The Provider Invoice is a two-part form. The provider must submit the original to the Department as indicated below. The copy of the claim is to be retained by the provider.

The pin-feed guide strip must be detached from the sides of continuous feed forms.

Claims must be mailed to the Department in the pre-addressed mailing envelope, Form DPA 1444, Provider Invoice Envelope, provided by the Department.

Claims with attachments must be mailed to the Department in the pre-addressed mailing envelope, DPA 2248, Special Approval Envelope, which is provided by the Department for this purpose.

APPENDIX E-1a

Reduced Facsimile of Form DPA 1443, Provider Invoice

PROVIDER INVOICE ILLINOIS DEPARTMENT OF PUBLIC AID										IDPA USE ONLY																			
ELITE PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>					TYPEWRITER ALIGNMENT <-----USE CAPITAL LETTERS ONLY----->										ELITE PICA <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>														
• • • • •										• • • • • NNN																			
1. PROVIDER NAME (First, Last)										2. Provider Number					3. Payee		4. Group		5. Role		6. Acc/Inj		7. Provider Reference						
8. Provider Street										9. Facility and City Where Service Rendered															10. Prior Approval				
11. Provider City										12. Referring Practitioner Name (First, Last)															13. Ref. Prac. No.				
14. Recipient Name, (First, MI, Last)					15. Recipient Number					16. Birthdate					17. H Kids		18. Fam Plar		19. Cr Child		20. St/Ab		21. Billing Date						
22. Primary Diagnosis															23. Prefix					24. Diag. Code									
25. Secondary Diagnosis															26. Prefix					27. Diag. Code									
28. Service Sections																													
1										Procedure Description / Drug Name, Form and Strength or Size										Proc. Code/Drug Item No.					Delete				
Date of Service		Cat. Serv.		Place of Serv		Units/Quanty		Modifying Units		TPL Code		Status		TPL Amount		Adjudication Date		Provider Charge											
2										Repeat Procedure Description / Drug Name, Form and Strength or Size										Proc. Code/Drug Item No.					Delete				
Date of Service		Cat. Serv.		Place of Serv		Units/Quanty		Modifying Units		TPL Code		Status		TPL Amount		Adjudication Date		Provider Charge											
Note: Center section of form has been removed to enlarge detail. The actual form has 7 Service Sections.																													
7										Repeat Procedure Description / Drug Name, Form and Strength or Size										Proc. Code/Drug Item No.					Delete				
Date of Service		Cat. Serv.		Place of Serv		Units/Quanty		Modifying Units		TPL Code		Status		TPL Amount		Adjudication Date		Provider Charge											
29. OPTICAL MATERIALS ONLY										Sec #		TPL Code		Status		TPL Amount		Adjudication Date		Total Charges									
										Sec #		TPL Code		Status		TPL Amount		Adjudication Date		Total Deductions									
Sec #		TPL Code		Status		TPL Amount		Adjudication Date		Net Charges																			
31. # Sects		32. Original DCN					33. Orig Voucher #					Uncoded TPL Name																	
<p>My signature certifies that: all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from this patient or any other third party will be properly credited or paid to the Illinois Department of Public Aid; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX of the Social Security Act and applicable State statutes; I provided or directly supervised all services for which a charge appears; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and consideration specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations.</p>																													
Signature															Date														
DPA 1443 (R-1-91) Completion mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment. Form Approved by the Forms Management Center. IL478-1210																													

APPENDIX E-2**TECHNICAL GUIDELINES FOR PAPER CLAIM PREPARATION
FORM DPA 2210, MEDICAL EQUIPMENT/SUPPLIES INVOICE**

Please follow these guidelines in the preparation of paper claims for imaging processing to assure the most efficient processing by the Department:

- Claims that are illegible will be returned to the provider.
- Claims with extreme print qualities, either light or dark, will not image.
- Use only one font style on a claim. Do not use bold print, italics, script, or any font that has connecting characters.
- Claims should be typed or computer-printed in capital letters. The character pitch must be 10-12 printed character per inch, the size of most standard pica or elite typewriters. Handwritten entries should be avoided.
- Do not use punctuation marks, slashes, dashes or any special characters anywhere on the claim form.
- All entries must be within the specified boxes. Do not write in the margins.
- Red ink does not image. Use only black ink for entries on the billing form, attachments and provider signature.
- If corrections need to be made, reprinting the claim is preferred. Correction fluid should be used sparingly.
- Remove the pin-feed strips on claims at the perforations only. Do not cut the strips, as it may alter the document size.
- Attachments containing a black border as a result of photocopying with the copier cover open cannot be imaged. Attachments must have a minimum one-half inch white border at the top and on the sides to ensure proper imaging of the document.
- For attachments containing gray areas, either as part of the original or as a result of photo-coping a colored background, print in the gray area is likely to be unreadable. If information in this area is important, the document should be recopied to eliminate the graying effect as much as possible without making the print too light.
- Attachments should be paper-clipped or rubber-banded to claims.

Appendix E-2a is a copy of Form DPA 2210, Medical Equipment/Supplies Invoice. Instructions for completion of the invoice follow in the order entries appear on the form. Mailing instructions follow the claim preparation instructions.

The left hand column of the following instructions identifies required and optional items for form completion as follows:

Required	=	Entry always required.
Optional	=	Entry optional - In some cases failure to include an entry will result in certain assumptions by the Department and will preclude the Department's correction of certain billing errors.
Conditionally Required	=	Entries which are required based on an entry in another field. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable to the provision of audiology services.

COMPLETION STATUS

ITEM

Document Control Number - leave blank.

- | | |
|-----------------|--------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 1. Provider Name - Enter the provider's name exactly as it appears on the Provider Information Sheet. |
| Required | 2. Provider Number - Enter the Provider Number exactly as it appears on the Provider Information Sheet. |
| Required | 3. Payee - Enter the one-digit code of the payee to whom payment is to be sent. Payees are coded numerically on the Provider Information Sheet. |

If no code is entered here, but the provider has designated more than one potential payee on the Provider Information Sheet, the claim will be rejected.

- | | |
|-------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 4. Billing Date - Enter the date the invoice was prepared. Use MMDDYY format. |
| Optional | 5. Provider Reference - Enter up to 10 numbers or letters used in the provider's accounting system for identification. If this field is filled in, the same data will appear on Form DPA M-194-1, Remittance Advice, returned to the provider. |
| Optional | 6. Provider Street - Enter the street address of the provider's primary office. If the address is entered, the Department will, where possible, correct claims suspended due to provider eligibility errors. If the address is not entered, the Department will not attempt corrections. |
| Optional | 7. Provider City State Zip - Enter city, state and zip code of provider. See item 6 above. |
| | 8. Service Sections: Complete one Service Section for each item or service provided to the patient. |
| Required | Recipient Name - Enter the patient's name exactly as it appears on the MediPlan Card, Temporary MediPlan Card or KidCare Card. Separate the components of the name (first, middle initial, last) in the proper sections of the name field. |
| Required | Recipient Number - Enter the nine-digit number assigned to the individual as copied from the MediPlan Card, Temporary MediPlan Card or KidCare Card. Use no punctuation or spaces. Do NOT use the Case Identification Number.

If the Temporary MediPlan Card does not contain the recipient number, enter the patient name and birthdate on the invoice and attach a copy of the Temporary MediPlan Card to the invoice. The Department will review the claim and determine the correct recipient number. See "Mailing Instructions" in this Appendix when a copy of the Temporary MediPlan Card is attached. |
| Conditionally Required | Birthdate - Enter the month, day and year of birth of the patient as shown on the Mediplan Card, Temporary Mediplan Card or KidCare Card. Use the MMDDYY format. |

**Conditionally
Required**

Acc/Inj - This is a one-digit numeric field. When applicable, enter one of the following Accident/Injury Codes to indicate the probable reason the patient sought treatment.

- 1 - Employment - The patient's injury is due to work related accident or illness.
- 2 - Motor Vehicle - The patient's injury was received while operating a motor vehicle or as a passenger in a motor vehicle, or another type of accident involving a motor vehicle.
- 3 - Athletic - The patient's injury is due to participation in an organized sport or school activity.
- 4 - Victim - The patient's injury is due to an act of violence (non-accidental).
- 5 - Other - The patient's injury is the result of an unspecified accident.

Not Required

Healthy Kids - Leave blank.

Not Required

Cr. Child - Leave blank.

**Conditionally
Required**

Delete - When an error has been made that cannot be corrected, enter an "X" to delete the entire Service Section. Only "X" will be recognized as a valid character; all others will be ignored.

Required

Diagnosis Description - Diagnosis description is required when a hearing aid is dispensed. Enter the diagnosis description for the condition responsible for the need for a hearing aid. (The diagnosis should be provided by the referring specialist or primary physician.)

**Conditionally
Required**

Prefix - When the diagnosis code in the ICD-9-CM has an alphabetic prefix of "E" or "V," enter it here.

Required	Diag. Code - Enter the ICD-9-CM code for the diagnosis described in "Diagnosis Description" field (item H above). All characters to the left of the decimal point should be entered to the left of the dividing line. All characters to the right of the decimal point should be entered to the right of the dividing line.
Conditionally Required	Ordering Practitioner Name - If the only service provided is evaluation for a hearing aid, no entry is required. For all other services or items, enter the name of the otologist or otolaryngologist (or primary physician) who referred the patient to the audiologist.
Conditionally Required	Ord. Prac. No. - If the ordering practitioner name is completed, enter the ordering practitioner's state license number, Social Security Number, or AMA number.
Not Required	Order Number - Leave blank.
Not Required	Prior Approval - Leave blank.
Required	Cat. Serv. - Enter the appropriate two-digit code for the category of service provided. The applicable codes which can be billed on this form are: 41 - Medical Equipment (for hearing aids and repairs) 48 - Supplies (for batteries)
Required	Item - Enter the appropriate five-digit HCPCS or Department-generated code for the service or item. Refer to Topic E-202 for information on obtaining a list of all covered services and items.
Required	Pur./Rent - Enter "1".
Required	Quantity - Enter the quantity. When a charge is being submitted for batteries, enter the number of individual batteries, not packages.
Required	Date of Service - Enter the date the service was provided. Use the MMDDYY format.

**Conditionally
Required**

TPL Code - If the patient's MediPlan or KidCare Card contains a TPL code, the code is to be entered in this field. If there is no TPL resource shown on the card, no entry is required except as follows.

SPENDDOWN - Refer to Chapter 100, Topic 113 for a full explanation of the Spenddown policy. If the patient has a Spenddown obligation, they will either be responsible for the total amount of the charge or will present the provider with a Form DPA 2432 (Split Billing Transmittal). When a Form DPA 2432 is necessary, Form DPA 2212, should be completed as follows:

- Enter 906 in the TPL CODE field.
- Enter a 01 in the TPL STATUS field if there is a patient liability or enter a 04 in the TPL STATUS field if there is no patient liability.
- From the Form DPA 2432, enter the amount from the LESS RECIPIENT LIABILITY AMOUNT field in the TPL AMOUNT field on the Form 2212. This amount may be \$0.00.
- From the Form DPA 2432, enter the DATE from the bottom of the form in the TPL DATE field of the Form DPA 2212.
- The TPL fields must be completed in each Service Section that has the same date of service as the SPLIT BILL day. The Spenddown liability is to be divided and reported in the TPL AMOUNT field of each Service Section that has the same date of service.

**Conditionally
Required**

Status - If a TPL code is shown, a two-digit code indicating the disposition of the third party claim must be entered. No entry is required if the TPL code = 000.

The TPL Status Codes are:

01 - TPL Adjudicated - total payment shown: TPL Status Code 01 must be entered when payment has been received from the patient's third party resource. The amount of payment received must be entered in the TPL amount box.

02 - TPL Adjudicated - patient not covered: TPL Status Code 02 must be entered when the provider is advised by the third party resource that the patient was not insured at the time services were provided.

03 - TPL Adjudicated - services not covered: TPL Status Code 03 must be entered when the provider is advised by the third party resource that services provided are not covered.

04 - TPL Adjudicated - spenddown met: TPL status code 04 must be entered when the patient's Form DPA 2432, Split Billing, shows \$0.00 liability.

05 - Patient not covered: TPL Status Code 05 must be entered when a patient informs the provider that the third party resource identified on the MediPlan Card is not in force.

06 - Services not covered: TPL Status Code 06 must be entered when the provider determines that the identified resource is not applicable to the service provided.

07 - Third Party Adjudication Pending: TPL Status Code 07 may be entered when a claim has been submitted to the third party, 60 days have elapsed since the third party was billed, and reasonable follow-up efforts to obtain payment have failed.

08 - Third Party Estimated Payment: TPL status code 08 must be entered when contact has been made with the third party and payment is forthcoming, but has not yet been received. The provider is responsible for initiating an adjustment if the actual amount of TPL monies received differs from the Estimated Amount reported.

10 - Deductible not met: TPL Status Code 10 must be entered when the provider has been informed by the third party resource that non-payment of the service was because the deductible was not met.

**Conditionally
Required**

TPL Amount - If there is no TPL code, no entry is required. Enter the amount of payment received from the third party health resource or the patient. A dollar amount entry is required if TPL Status Code 01 or 08 was entered in the "Status" box.

**Conditionally
Required**

TPL Date - A TPL date is required when any Status code is shown. Use the date specified below for the applicable code:

Code Date to be entered

- 01 - Third Party Adjudication Date
- 02 - Third Party Adjudication Date
- 03 - Third Party Adjudication Date
- 04 - Date from the DPA 2432
- 05 - Date of Service
- 06 - Date of Service
- 07 - Date of Submittal to TPL Resource
- 10 - Third Party Adjudication Date

Required

Provider Charge - Enter the total charge for the service, not deducting any TPL.

Optional

Repeat - In the second through seventh Service Sections, a field titled "Repeat" appears at the beginning of the Service Section. This field may be used, by entry of a capital "X" in the box, to eliminate the need to repeat any data field except the Date of Service and any TPL related fields.

**Conditionally
Required**

9. **Uncoded TPL Name** - Enter the name of the third party health resource. The name must be entered if TPL code 999 is used.

ITEMS 10 AND 11 HAVE BEEN DELETED**Conditionally
Required**

12. **Sec. #** - This field must be completed either when there is additional TPL for a specific Service Section or the TPL is to be applied to all Service Sections on the invoice. If the TPL data is for a specific Service Section, the Service Section number must be entered in this field. If the TPL is to be applied to all Service Sections, an "O" must be entered in this field.

- | | |
|-------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Conditionally Required | 13A. TPL Code - Refer to item 8 for the instructions for the TPL code. |
| Conditionally Required | 13B. Status - Refer to item 8 for the instructions for the TPL status. |
| Conditionally Required | 13C. TPL Amount - Refer to item 8 for the instructions for the TPL amount. |
| Conditionally Required | 13D. TPL Date - Refer to item 8 for the instructions for the TPL date. |
| Required | 14. # Sects. - Enter the total number of Service Sections completed correctly in the top part of the invoice. This entry must be at least 1 and no more than 5. Do not count any sections which were deleted because of errors. |

The three claim summary fields must be completed on all Medical Equipment/Supplies Invoices. These fields are Total Charge, Total Deductions and Net Charge. They are to be completed in accordance with the following instructions

- | | |
|-----------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 15. Total Charge - Enter the sum of all charges submitted on the Provider Invoice in Service Sections 1 through 5. |
| Required | 16. Total Deductions - Enter the sum of all payments received from other sources. If no payment was received, enter three zeroes (000). |
| Required | 17. Net Charge - Enter the difference between Total Charge and Total Deductions. |
| Required | 18. Provider Certification, Signature and Date - After reading the certification statement, the provider must sign the completed form. The signature must be handwritten in black or dark blue ink. A stamped or facsimile signature is not acceptable. Billing forms received with a stamped or facsimile signature will be rejected. Unsigned Provider Invoices will not be accepted by the Department and will be returned to the provider when possible. The signature date must be entered. |

MAILING INSTRUCTIONS

The Medical Equipment/Supplies Invoice is a two-part form. The provider must submit the original to the Department as indicated below. The copy of the claim should be retained by the provider.

The pin-feed guide strip should be detached from the sides of continuous feed forms.

Claims must be mailed to the Department in the pre-addressed mailing envelope, DPA 2247, Medical Equipment/Supplies Invoice Envelope, provided by the Department.

Claims with attachments must be mailed to the Department in pre-addressed mailing envelope, Form DPA 2248, Special Approval Envelope, which is provided by the Department.

APPENDIX E-2a

Reduced Facsimile of Form DPA 2210, Medical Equipment/Supplies Invoice

MEDICAL EQUIPMENT / SUPPLIES INVOICE ILLINOIS DEPARTMENT OF PUBLIC AID						IDPA Use only			
ELITE <input type="checkbox"/> PICA <input type="checkbox"/>		TYPEWRITER ALIGNMENT USE CAPITAL LETTERS ONLY				ELITE <input type="checkbox"/> PICA <input type="checkbox"/>		222	

1. Provider Name		2. Provider Number		3. Payee	4. Billing Date		5. Provider Reference	
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>		<input style="width: 50%;" type="text"/>	<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	
6. Provider Street		7. Provider City		State		Zip		
<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>		

8. Sections	Service Recipient Name, (First, MI, Last)		Recipient Number	Birthdate	Acc./Inj.	H.Kids	Cr.Child	Delete
	<input style="width: 100%;" type="text"/>		<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/>
Diagnosis Description Prefix <input style="width: 50%;" type="text"/> Diag. <input style="width: 50%;" type="text"/> Code <input style="width: 50%;" type="text"/>								
Ordering Practitioner Name (First, Last) Ord.Prac.No. <input style="width: 50%;" type="text"/> Order Number <input style="width: 50%;" type="text"/> Prior Approval <input style="width: 50%;" type="text"/>								
Cat. Serv.	Item	Pur./Rent	Quantity	Date of Service	TPL Code	Status	TPL Amount	Provider Charge
<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	\$ <input style="width: 50%;" type="text"/>

2	Repeat Recipient Name, (First, MI, Last)		Recipient Number	Birthdate	Acc./Inj.	H.Kids	Cr.Child	Delete
	<input checked="" type="checkbox"/>		<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/>
Diagnosis Description Prefix <input style="width: 50%;" type="text"/> Diag. <input style="width: 50%;" type="text"/> Code <input style="width: 50%;" type="text"/>								
Ordering Practitioner Name (First, Last) Ord.Prac.No. <input style="width: 50%;" type="text"/> Order Number <input style="width: 50%;" type="text"/> Prior Approval <input style="width: 50%;" type="text"/>								
Cat. Serv.	Item	Pur./Rent	Quantity	Date of Service	TPL Code	Status	TPL Amount	Provider Charge
<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	\$ <input style="width: 50%;" type="text"/>

Note: Center section of form has been removed to enlarge detail. The actual form has 5 service sections.

Recipient Name, (First, MI, Last)		Recipient Number	Birthdate	Acc./Inj.	H.Kids	Cr.Child	Delete
<input checked="" type="checkbox"/>		<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input checked="" type="checkbox"/>
Diagnosis Description Prefix <input style="width: 50%;" type="text"/> Diag. <input style="width: 50%;" type="text"/> Code <input style="width: 50%;" type="text"/>							
Ordering Practitioner Name (First, Last) Ord.Prac.No. <input style="width: 50%;" type="text"/> Order Number <input style="width: 50%;" type="text"/> Prior Approval <input style="width: 50%;" type="text"/>							
Cat. Serv.	Item	Pur./Rent	Quantity	Date of Service	TPL Code	Status	Provider Charge
<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	\$ <input style="width: 50%;" type="text"/>

9. Uncoded TPL Name					14. #Sects		15. Total Charge	
<input style="width: 100%;" type="text"/>					<input style="width: 50%;" type="text"/>		\$ <input style="width: 50%;" type="text"/>	
12. Sec.#	13A. TPL Code	13B. Status	13C. TPL Amount	13D. TPL	16. Total Deductions			
<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	<input style="width: 50%;" type="text"/>	\$ <input style="width: 50%;" type="text"/>			
My signature certifies that: all entries on this claim are true, accurate and complete; the State's Medical Assistance Program pricing limits will be accepted as payment in full; any payments received from the patient or any other third party will be properly credited or paid to the Illinois Department of Public Aid; records necessary to fully disclose the nature and extent of services provided are maintained and will be made available upon request of State and Federal officials responsible for the various aspects of the State's Medical Assistance Program, as provided under Title XIX of the Social Security Act and applicable State statutes; I am duly authorized as a representative of the entity to be reimbursed by this claim; I understand payment is made from State and Federal funds and that any falsification or concealment of material fact may lead to appropriate legal action; in compliance with the Civil Rights Act of 1964, services were provided without discrimination on the grounds of race, color or national origin; and handicapped persons are afforded the rights and considerations specified in Section 504 of the Rehabilitation Act of 1973 and Part 84 of the Code of Federal Regulations. <small>*Completion mandatory, IL Rev.Stat., Ch. 23, P.A.Code, penalty non-payment. Form Approved by the Forms Management Center.*</small>					17. Net Charge			
					\$ <input style="width: 50%;" type="text"/>			

IL 478-1105 DPA 2210 (R) - 3 - 94	Provider Signature	Date
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APPENDIX E-3

PREPARATION AND MAILING INSTRUCTIONS FOR FORM DPA 2240, EQUIPMENT PRIOR APPROVAL REQUEST

Form DPA 2240, Equipment Prior Approval Request, must be submitted by the provider for certain specified services in order for the services to qualify for reimbursement. Services requiring prior approval are identified in the handbook.

Appendix E-3a contains a facsimile of Form DPA 2240. The form provides space to request up to three items for the same patient.

INSTRUCTIONS FOR COMPLETION

The form must be typewritten or legibly handprinted. Instructions for completion follow in the order entries appear on the form. Mailing instructions follow the form preparation instructions.

The left hand column of the following instructions identifies mandatory and optional items for form completion as follows:

Required	=	Entry always required. If any required items are left blank, the form will be returned as invalid.
Conditionally Required	=	Entries which are required based on an entry in another field. Conditions of the requirement are identified in the instruction text.
Not Required	=	Fields not applicable for services by audiologists; leave blank.

ITEM EXPLANATION AND INSTRUCTIONS

- | | | |
|--------------|-----------|-------------------------------------------------------------------------------------------------------------------------|
| Not Required | 1. | Trans Code (Transaction Code) - Leave blank. |
| Not Required | 2. | Prior Approval Number - Leave blank. |
| Not Required | 3. | Case Name - Leave blank. The case name appears on the front of the card in conjunction with the mailing address. |

- | | | |
|--------------|-----|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Required | 4. | Recipient Name - Enter the name of the patient for whom the service is requested. |
| Required | 5. | Recipient Number - Enter the nine-digit recipient number assigned to the patient for whom the service is requested. This number is found to the right of the patient's name on the back of the MediPlan or KidCare Card. |
| Required | 6. | Birthdate - Enter the patient's birthdate. |
| Not Required | 7. | Inst Set (Institutional Setting) - Leave blank. |
| Not Required | 8. | Case Identification Number - Leave blank. This number is found in the primary portion (front) of the card immediately above the case name and mailing address. |
| Required | 9. | Recipient Street Address - Enter the patient's current street address. |
| Required | 10. | Diagnosis Description - Enter the written diagnosis which describes the condition primarily responsible for the need for the item being requested. |
| Required | 11. | Recipient City, State, Zip - Refer to Item 9 above. |
| Required | 12. | Diagnosis Code - Enter the ICD-9-CM diagnosis code that corresponds to the diagnosis described in item 10 above. |
| Required | 13. | Ordering Provider Name - Enter the name of the otologist, otolaryngologist or primary care physician recommending the patient receive the specific item/service. |
| Required | 14. | Order. Prov. No. (Ordering Provider Name) - Enter the ordering physician's state medical license number, UPIN, social security number or the provider number assigned by the Department. |

- | | | |
|--------------|-----|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Not Required | 15. | Facility Name - Leave blank. |
| Required | 16. | Provider Street - Enter the ordering physician's street address. |
| Required | 17. | Provider Telephone - Enter the telephone number of the ordering physician's office. |
| Not Required | 18. | Facility City - Leave blank. |
| Required | 19. | Provider City, State, Zip - Enter the city, state, and zip code of the ordering physician. |
| Required | 20. | Supplying Provider Name - Enter the name of the provider who will render the service. |
| Required | 21. | Supply Prov No (Supplying Provider Number) - Enter the supplying provider's number exactly as shown on the Provider Information Sheet. |
| Required | 22. | Provider Street - Enter the supplying provider's street address. |
| Required | 23. | Provider Telephone - Enter the telephone number of the supplying provider's office. |
| Required | 24. | Provider City, State, Zip - Enter the city, state, and zip code of the supplying provider. This information is helpful in instances where the Department needs additional information in order to act upon the request. |
| Not Required | 25. | Approving Authority - Leave blank. |
| Not Required | 26. | Disposition Date - Leave blank. |
| Not Required | 27. | Approving Authority Signature - Leave blank. |

Not Required	28. Receipt Date - Leave blank.
Required	29. Service Sections - The form provides space to request a maximum of three services. When more than three services are requested, a second form must be completed. Instructions for completion of entry fields contained within a service section follow:
Required	Req. Item No. (Requested Item Number) - Enter the appropriate five-digit CPT, HCPCS or Department-generated code for the service or item. Refer to Topic E-202 for information on obtaining a list of all covered services and items.
Required	Req Qty (Requested Quantity) - Enter the number of items to be dispensed in the period covered by the prior approval.
Required	Prov Charge (Provider Charge) - Enter the provider's usual and customary charge.
Required	Cat. Serv. (Category of Service) - Enter the appropriate two-digit code of either 41 or 48.
Required	Description - Briefly describe the service or item to be provided. If an item has been delivered, enter the date of service. If additional space is needed, provide the information on letterhead paper, identifying the patient by name and Recipient Identification Number.
Not Required	Disposition Status - Leave blank.
Not Required	Aprv Item No. (Approved Item Number) - Leave blank.
Not Required	Aprv Qty (Approved Quantity) - Leave blank.

Not Required	Unit Amount - Leave blank.
Required	Purchase/Rental - Enter "1".
Not Required	Total Amount - Leave blank.
Conditionally Required	Begin Date - If an item or service has already been dispensed, enter the date the item or service was provided. If the item or service will not be provided until the prior approval request is granted, leave this item blank.
Not Required	End Date - Leave blank. The approving authority will enter the last day on which the item or service may be provided.
Not Required	Reason For Denial - Leave blank.
Conditionally Required	30. Medical Necessity/Additional Diagnoses - The provider must enter a statement as to the need for the item(s) or service(s) requested, how the item or service is expected to correct or help the condition, and why the requested treatment plan is better than any other plan commonly used to deal with similar diagnoses or conditions. If additional space is needed, provide the information on letterhead paper, identifying the patient name and Recipient Identification Number.
Required	31. Supplying Provider Signature - The form must be signed in ink by the individual who is to provide the item or service.
Required	32. Request Date - Enter the date the form is signed.

MAILING INSTRUCTIONS

Before mailing, carefully review the request for completeness and accuracy. Attach documentation for hearing aid requests as specified in the handbook. The top, signed copy of the request must be mailed to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
Post Office Box 19124
Springfield, Illinois 62794-9124
(Use pre-addressed envelopes, Form DPA 2294, Equipment Supplies Prior
Approval Envelope, supplied by the Department.)

A notification of approval or denial of the service(s) will be mailed to the provider.

APPENDIX E-3a

Reduced Facsimile of Form DPA 2240, Equipment Prior Approval Request

EQUIPMENT PRIOR APPROVAL REQUEST						Document Control Number																																					
Illinois Department of Public Aid						EEE																																					
1. Trans Code		2. Prior Approval Number		3. Case Name																																							
<input type="text"/>		<input type="text"/>		<input type="text"/>																																							
4. Recipient Name (First, MI, Last)			5. Recipient Number		6. Birthdate		7. Inst. Set																																				
<input type="text"/>			<input type="text"/>		<input type="text"/>		<input type="text"/>																																				
9. Recipient Street				10. Diagnosis Description																																							
<input type="text"/>				<input type="text"/>																																							
11. Recipient City		State		Zip		12. Diagnosis Code																																					
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																																					
13. Ordering Provider Name				14. Order Prov.No.		15. Facility Name																																					
<input type="text"/>				<input type="text"/>		<input type="text"/>																																					
16. Provider Street				17. Provider Telephone		18. Facility City																																					
<input type="text"/>				<input type="text"/>		<input type="text"/>																																					
19. Provider City		State		Zip		21. Supply Prov.No.																																					
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																																					
20. Supplying Provider Name				23. Provider Telephone		28. Receipt Date																																					
<input type="text"/>				<input type="text"/>		<input type="text"/>																																					
22. Provider Street		State		Zip		27. Approving Authority Signature																																					
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																																					
24. Provider City		State		Zip		25. Aprv. Authority																																					
<input type="text"/>		<input type="text"/>		<input type="text"/>		<input type="text"/>																																					
26. Disp. Date		27. Approving Authority Signature		28. Receipt Date																																							
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29. SERVICE SECTIONS																																											
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 5%; text-align: center;">1</td> <td style="width: 20%;">Req. Item No.</td> <td style="width: 10%;">Req. Qty.</td> <td style="width: 15%;">Prov. Charge</td> <td style="width: 10%;">Cat. Serv</td> <td style="width: 50%;">Description</td> </tr> <tr> <td></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> <tr> <td>DISP</td> <td>Aprv. Item No.</td> <td>Aprv. Qty.</td> <td>Unit Amount</td> <td>Purchase/Rental</td> <td></td> </tr> <tr> <td>STATUS</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> </tr> <tr> <td><input type="checkbox"/></td> <td>Total Amount</td> <td>Begin Date</td> <td>End Date</td> <td></td> <td>Reason For Denial</td> </tr> <tr> <td>0=Denied</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td></td> <td><input type="text"/></td> </tr> </table>								1	Req. Item No.	Req. Qty.	Prov. Charge	Cat. Serv	Description		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	DISP	Aprv. Item No.	Aprv. Qty.	Unit Amount	Purchase/Rental		STATUS	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="checkbox"/>	Total Amount	Begin Date	End Date		Reason For Denial	0=Denied	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>
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3	Req. Item No.	Req. Qty.	Prov. Charge	Cat. Serv	Description																																						
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0=Denied	<input type="text"/>	<input type="text"/>	<input type="text"/>		<input type="text"/>																																						
30. Medical Necessity/Additional Diagnoses					This is to certify that the information above is true, accurate and complete.																																						
<input type="text"/>					31. Supplying Provider Signature																																						
					32. Request Date																																						
					IL478-1070																																						

Completion Mandatory, Ill. Rev. Stat., Ch. 23, P.A. Code, penalty non-payment.
DPA 2240 (R-11-91)

APPENDIX E-3b

Facsimile of
BINAURAL HEARING AID QUESTIONNAIRE

Patient Name _____ Recipient ID# _____

In order to make an informed recommendation to approve or deny a binaural hearing aid system, our physician consultants need the following information:

- 1) Why is it **necessary** this patient have a binaural system?

- 2) Is the patient's hearing in the poorer ear 25 dB. less than the hearing in the better ear? _____
- 3) Could "Cros" hearing aids be considered? _____
- 4) Is the patient going to school, vocational training, or working in a dangerous area where sound from both sides is essential? _____

Please explain:

Without this information being supplied for our review, a request cannot be considered for either approval or denial.

Signed _____
Ordering Physician

Date _____

M-206.26a

APPENDIX E- 4

PREPARATION AND MAILING INSTRUCTIONS FOR MEDICARE/MEDICAID COMBINATION CLAIMS

Chapter 100, Topic 120.1 provides general guidance for claim submittal and payment when a patient is covered by both Medicare and Medicaid. These are generally referred to as combination claims. This Appendix provides detailed instructions for coding Medicare claims to facilitate proper consideration for payment of co-insurance and deductibles by the Department.

Coding and Submission of Claims to the Medicare Intermediary or DMERC

Charges for services provided to covered participants who are also eligible for Medicare benefits must be submitted to the Medicare intermediary on Form HCFA 1500. The words "Illinois Department of Public Aid" or "IDPA" and the patient's nine- digit Recipient Identification Number are to be entered in Field 9a of the Form HCFA 1500. Field 27 must be marked "Yes", indicating the provider will accept assignment.

In many instances, this entry will cause the claim to "cross over", that is, the claim will be forwarded to the Department by the Medicare intermediary automatically, without any further action by the provider. This is referred to as a crossover claim. When a claim crosses over, the Explanation of Medicare Benefits (EOMB) will contain a message or code indicating that the claim has been sent to the Department. The claim will appear later on a Department Remittance Advice after it has been adjudicated.

Submission of Claims That Do Not Automatically Cross Over

For consideration of payment of the coinsurance and deductible, the provider must submit the claim directly to the Department when:

- payment is made by the Medicare intermediary but the EOMB does not show that the claim has been crossed over, or
- when more than 90 days has elapsed since the Medicare payment but the claim has not appeared on a Department Remittance Advice.

Submit a copy of Form HCFA 1500 with a copy of the Medicare EOMB or the Medicare payment voucher.

Prior to submitting the claim to the Department, the following additional information must be entered on Form HCFA 1500:

- the provider name in Field 33 exactly as it appears on the Provider Information Sheet,
- the provider's Provider Number in the lower right corner of Field 33, and
- the one-digit provider payee code (if the provider has multiple payees listed on the Provider Information Sheet) in Field 33 immediately following the Provider Name.

If the HCFA 1500 submitted to Medicare lists services of two or more practitioners, a

separate claim and EOMB is required for each. In addition, the services provided by each practitioner must be identified.

The disposition of the claim will be reported on the Department's Remittance Advice.

Provider Action on Services Totally Rejected by Medicare

The Department's liability for payment is generally based on Medicare's determination as to medical necessity and utilization limits. Before submitting a denied claim to the Department, the provider should review the reason for Medicare's denial to determine if submittal of the claim is indicated. In general, the provider should submit a claim to the Department for payment consideration only when the reason for Medicare's denial of payment is either:

- the patient was not eligible for Medicare benefits or
- the service is not covered as a Medicare benefit.

In such instances, the Department is to be billed only after final adjudication of the claims by the Medicare intermediary. If the provider has requested a reconsideration of Medicare's denial, the Department is not to be billed until after Medicare's reconsideration decision.

Claims which have been denied by Medicare for which the provider is seeking payment must be submitted on a Form DPA 1443 or Form DPA 2210 with a copy of the EOMB attached. If Medicare reconsideration was requested and denied, a copy of the reconsideration decision and any correspondence should also be attached.




APPENDIX E-5

EXPLANATION OF INFORMATION ON PROVIDER INFORMATION SHEET

The Provider Information Sheet is produced when a provider is enrolled in the Department's Medical Programs. It will also be generated when there is a change or update to the provider record. This sheet will then be mailed to the provider and will serve as a record of all the data that appears on the Provider Data Base.

If, after review, the provider notes that the Provider Information Sheet does not reflect accurate data, the provider is to line out the incorrect information, note the correct information, sign the document and return it to the Provider Participation Unit in Springfield, Illinois. Refer to Topic E-201.4 for instructions. If all the information noted on the sheet is correct, the provider should keep the document and reference it when completing any Department forms.

The following information will appear on the Provider Information Sheet. A sample of a Provider Information Sheet is attached as Appendix E-5a. The item or area numbers that correspond to the explanations below appear in small circles  on the sample form.

FIELD	EXPLANATION
 PROVIDER KEY	This number uniquely identifies the provider and must be used as the provider number when billing charges to the Department.
 PROVIDER NAME AND LOCATION	This area contains the NAME AND ADDRESS of the provider as carried in the Department's records. The three-digit COUNTY code identifies the county in which the provider maintains his primary office location. It is also used to identify a state if the provider's primary office location is outside of Illinois. The TELEPHONE NUMBER is the primary telephone number of the provider's primary office.
 ENROLLMENT SPECIFICS	<p>This area contains basic information reflecting the manner in which the provider is enrolled with the Department.</p> <p>PROVIDER TYPE is a three-digit code and corresponding narrative which indicates the provider's classification.</p> <p>ORGANIZATION TYPE is a two-digit code and corresponding narrative indicating the legal structure of the environment in which</p>

the provider primarily performs services. The possible codes are:

01 = Individual Practice

02 = Partnership

03 = Corporation

ENROLLMENT STATUS is a one-digit code and corresponding narrative which indicates whether or not the provider is currently an active participant in the Department's Medical Programs. The possible codes are:

B = Active

I = Inactive

N = Non Participating

Disregard the term NOCST if it appears in this item.

Immediately following the enrollment status indicator are the **BEGIN** date indicating when the provider was most recently enrolled in Department's Medical Programs and the **END** date indicating the end of the provider's most current enrollment period. If the provider is still actively enrolled, the word "ACTIVE" will appear in the **END** date field.

EXCEPTION INDICATOR may contain a one-digit code and corresponding narrative indicating that the provider's claims will be reviewed manually prior to payment. The possible codes are:

A = Intent to Terminate

B = Expired License

C = Citation to Discover Assets

D = Delinquent Child Support

F = Fraud Investigations

G = Garnishment

I = Indictment

L = Student Loan Suspensions

R = Intent to Terminate/Recovery

S = Exception Requested By Provider Participation Unit

T = Tax Levy

X = Tax Suspensions

If this item is blank, the provider has no exception.

Immediately following the **EXCEPTION INDICATOR** are the **BEGIN** date indicating the first date when the provider's claims were to be manually reviewed and the **END** date indicating the last date the provider's claims were to be manually reviewed. If the provider has no exception, the date fields will be blank.

AGR (Agreement) indicates whether the provider has a form DPA 1413, Provider Agreement, on file and the provider is eligible to submit claims electronically. Possible entries are YES or NO.

**4 CERTIFICATION/
LICENSE NUMBER**

This is a unique number identifying the license issued by a state agency authorizing a provider to practice or conduct business. This entry is followed by the **ENDING** date indicating when the license will expire.

5 S.S.#

This is the provider's Social Security or FEIN number.

**6 ELIGIBILITY
CATEGORY
OF SERVICE**

ELIGIBILITY CATEGORY OF SERVICE contains one or more three-digit codes and corresponding narrative indicating the types of service a provider is authorized to render to patients covered under the Department's Medical Programs. The possible codes are:

014 = Audiology Services

041 = Medical Equipment/Prosthetic Devices

048 = Medical Supplies

Each entry is followed by the date that the provider was approved to render services for each category listed.

The provider is not to include the "0" in the above code when completing the Category of Service field on billing invoices.

**7 PAYEE
INFORMATION**

This area records the name and address of any persons or entities authorized to receive payments on behalf of the provider. Each potential payee is assigned a single-digit **PAYEE CODE**, which must be used on the claim form to designate the payee to whom the warrant is to be paid.

If no payee number is designated on a claim form, but multiple payees are shown on the Provider Information Sheet, the claim will be rejected.

PAYEE ID NUMBER is a sixteen-digit identification number assigned to each payee to whom warrants may be issued. A portion of this number is used for tax reporting purposes; therefore, no payments can be made to a payee unless the number is on file. To the right of this number is the effective date when payment may be made to each payee on behalf of the provider.

The **MEDICARE/PIN** or the **DMERC #** is the number assigned to

the payee by the Medicare Carrier to cross-over Medicare billable services. The **PIN** is the number assigned by Medicare to a provider within a group practice, if applicable.

8 SIGNATURE

The provider is required to affix an original signature when submitting changes to the Department of Public Aid.

APPENDIX E-5a

Reduced Facsimile of Provider Information Sheet

1 MEDICAID SYSTEM (MMIS)
 PROVIDER SUBSYSTEM
 REPORT ID: A2741KD1
 SEQUENCE: PROVIDER TYPE
 PROVIDER NAME

2 STATE OF ILLINOIS
 DEPARTMENT OF PUBLIC AID
 PROVIDER INFORMATION SHEET

3 RUN DATE: 11/02/99
 RUN TIME: 11:47:06
 MAINT DATE: 11/02/99
 PAGE: 84

1 --PROVIDER KEY--
 333333333001

PROVIDER NAME AND ADDRESS
 DOE, DORIS
 1441 MY STREET
 ANYTOWN, IL 62222-2222

PROVIDER TYPE: 025 - AUDIOLOGIST
 ORGANIZATION TYPE: 01 - INDIVIDUAL PRACT
 ENROLLMENT STATUS B - ACTIV NOCST BEGIN 12/27/98 END ACTIVE
 EXCEPTION INDICATOR - BEGIN END
 AGR: NO BILL: NONE

PROVIDER GENDER:
 COUNTY 058-LASALLE
 TELEPHONE NUMBER: (888) 123-4567
 D.E.A. #:
 RE-ENROLLMENT INDICATOR: N

CERTIFIC/LICENSE NUM - 040011111 ENDING 03/31/02
 LAST TRANSACTION COR AS OF 12/18/98
 DATE: 12/27/98

S.S. # 331313131
 CLIA #

ELIG			ELIG		
COS	ELIGIBILITY CATEGORY OF SERVICES	BEG DATE	COS	ELIGIBILITY CATEGORY OF SERVICE	BEGIN DATE
014	AUDIOLOGY SERVICES	12/27/98	041	MED EQUIP/PROSTHETIC DEVICES	12/27/98
048	MEDICAL SUPPLIES	12/27/98			

6 PAYEE

CODE	PAYEE NAME	PAYEE STREET	PAYEE CITY	ST	ZIP	PAYEE ID NUMBER	DMERC#	EFF DATE
1	DR DOE DORIS	1441 MY STREET	ANYTOWN	IL	62222	331313131-60077-01		12/27/98

DBA: AUDIOLOGY SERVICES INC
 MEDICARE/PIN:
 VENDOR ID: 30

7

***** PLEASE NOTE: *****

* ORIGINAL SIGNATURE OF PROVIDER REQUIRED WHEN SUBMITTING CHANGES VIA THIS FORM: DATE: _____ X _____

8